When my proposal was accepted, the door opened to several months of intensive research.

In interviewing many of the leading figures in the field and reading up on the literature, I caught a glimpse of the medical world that patients seldom see. It's not the brave face of conviction and confidence that one usually sees in the clinician. Instead, it's a world fraught with controversy, disputes over research results, and questions that won't go away: What about the efficacy of the PSA test? What about the advisability of the increasingly popular radical prostatectomy? What about the studies from Scandinavia apparently showing that surgery was no more effective in saving lives than watchful waiting?

When I raised these questions with a world-renowned specialist in the field, the interview ended after 20 minutes. The surgeon picked up his telephone and called security to have me removed from the building. For a fleeting moment, I felt like the character Harrison Ford plays in the movie *The Fugitive* as I crept around the frozen streets, attempting to sneak back into the hospital to finish my interviews.

When I completed the documentary, I had a small sense of satisfaction that I was able to send up a warning to listeners to be wary of the sweeping claims made about prostate cancer treatment. I became keenly aware of any and all media reports on the topic. The ones that gave me the most concern were those that uncritically endorsed PSA testing and prostatectomy as a remedy for prostate cancer.

Only regular readers of the *Wall Street Journal* would be aware of the very large financial implications of this debate. The PSA test costs around $50. Multiply that by the millions of men over age 50 who might be persuaded that a yearly PSA is a good idea. There is the possibility that the number of prostatectomies could grow to 100,000 per year, without any scientific proof so far that this kind of surgery prolongs life any better than watchful waiting.

I'm just not sure that I'm better off knowing all these things.

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Mass immunization: did we do more harm than good?

see also p.392

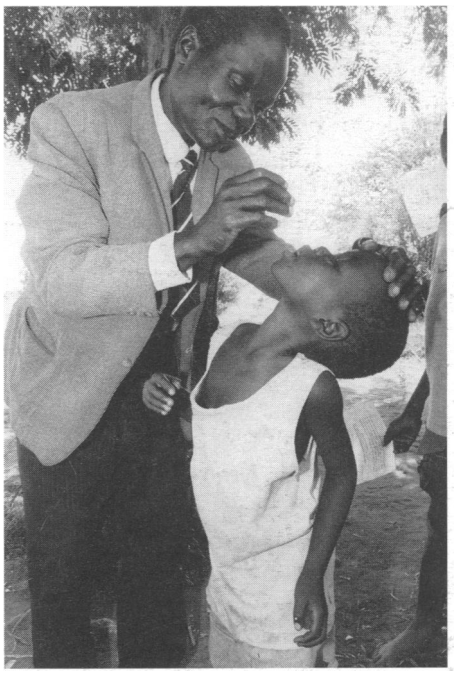
David Heiden

By 1983 the health care system in Uganda was in shambles. It was the immediate aftermath of Idi Amin, and during his 10-year rule, the childhood immunization program had fallen apart. Measles was the leading reported cause of death in the country, and more hospital beds were occupied by patients with measles than for any other disease.

I was there to help restart primary immunization—measles, polio, DPT, and BCG. We knew we were doing something that was needed because almost every day we saw children with withered limbs from polio. In a month we had trained several teams and immunized about 25,000 children. But thinking back on the experience makes me reflect on the complexity of even something as simple as immunization, and the ever-lurking possibility of good intentions leading to more harm than good.

For example, on our third morning we discovered a problem with the "cold chain." The cold packs had been put in the refrigerator instead of the freezer, and they weren't frozen. Without frozen cold packs we couldn't keep measles vaccine viable in the equatorial African heat. At 9 AM we put the packs in the freezer, but by 2 PM they still weren't frozen. It was 4:30 when I finally arrived at the Busia market, the morning immunization site, to explain that the vaccinations had to be cancelled. The local nurse said that there had been an excellent turnout, about 1,000 children and mothers, plus the village chief, schoolteachers, and clergy, who had been working for weeks to remind and encourage everyone to come. But now, all the people were gone. The crowd had arrived at 8 AM. It had been hot. There was no water and no lunch for the children. The nurse said that the chief had made very nice speeches about immunization all morning, trying to keep the people patient. At noon they sent everyone on foot to the afternoon site 6 miles away. By the time we drove to the afternoon site, everyone was gone except for 6 men sitting in a hut drinking Pombe, the local homemade beer.

Then, in the second week, something worse happened. We drove 2 hours over rutted dirt tracks to reach the appointed village. We unpacked, only to discover that we had left the box of needles behind. The local schoolteachers and village priest who had organized the turnout and had dressed in their best clothes greeted us with nervous eagerness and pride. They had done wonderfully: there were 700 children crowded into the village center. Again, many of the mothers had come 5 or 10 miles on foot.



David Heiden

A teacher administering oral polio vaccine

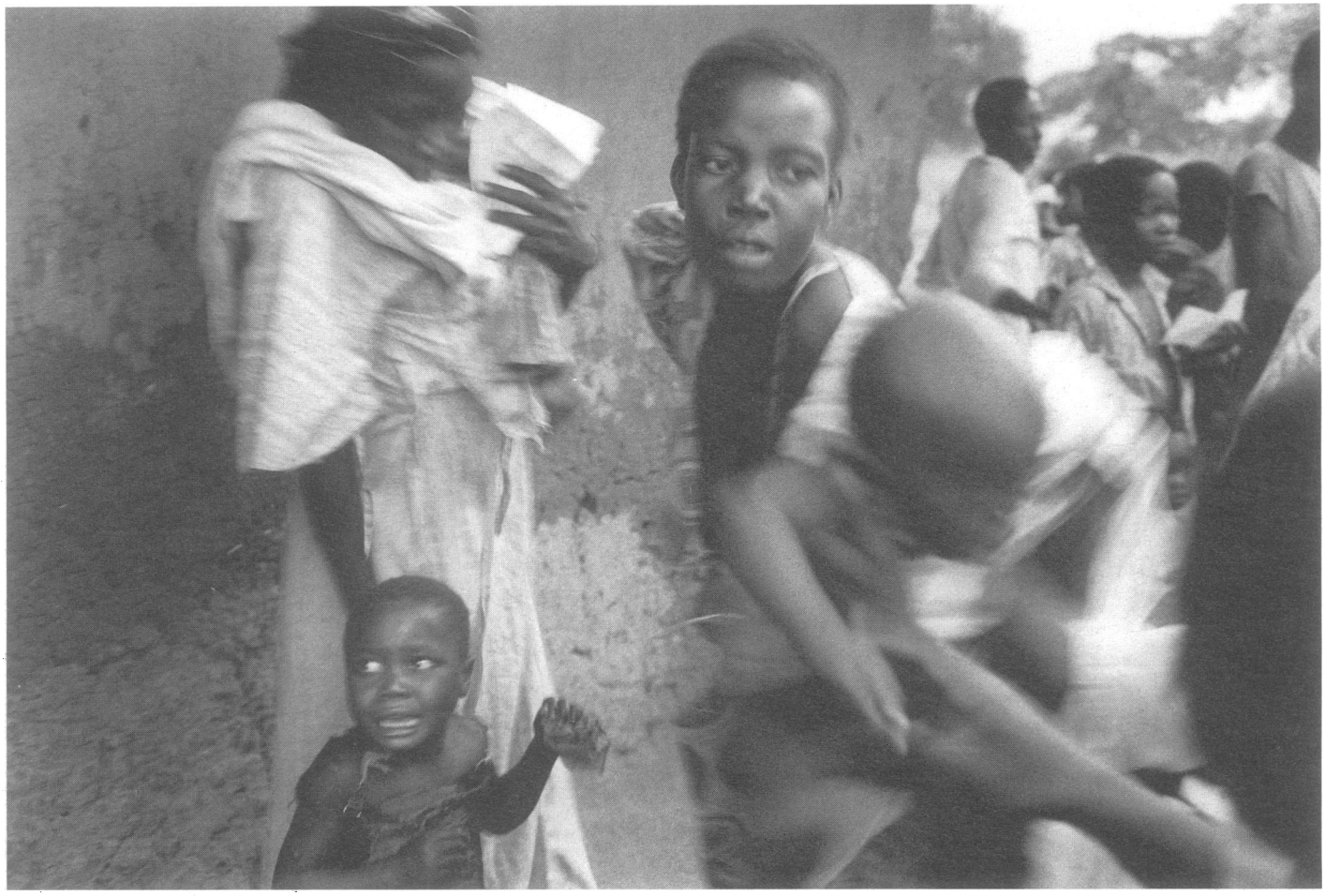
But we had only two needles. We argued about what to do but finally went ahead, reusing the same 2 disposable needles on 700 children. We didn't know that by 1983 HIV infection had taken hold in Uganda. I can't help wondering if we contributed to the epidemic by our work that day.

—David Heiden, *ophthalmologist, San Francisco*

Uganda, May 1983—
Immunization, Tororo region.

see text p.383

David Heiden



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